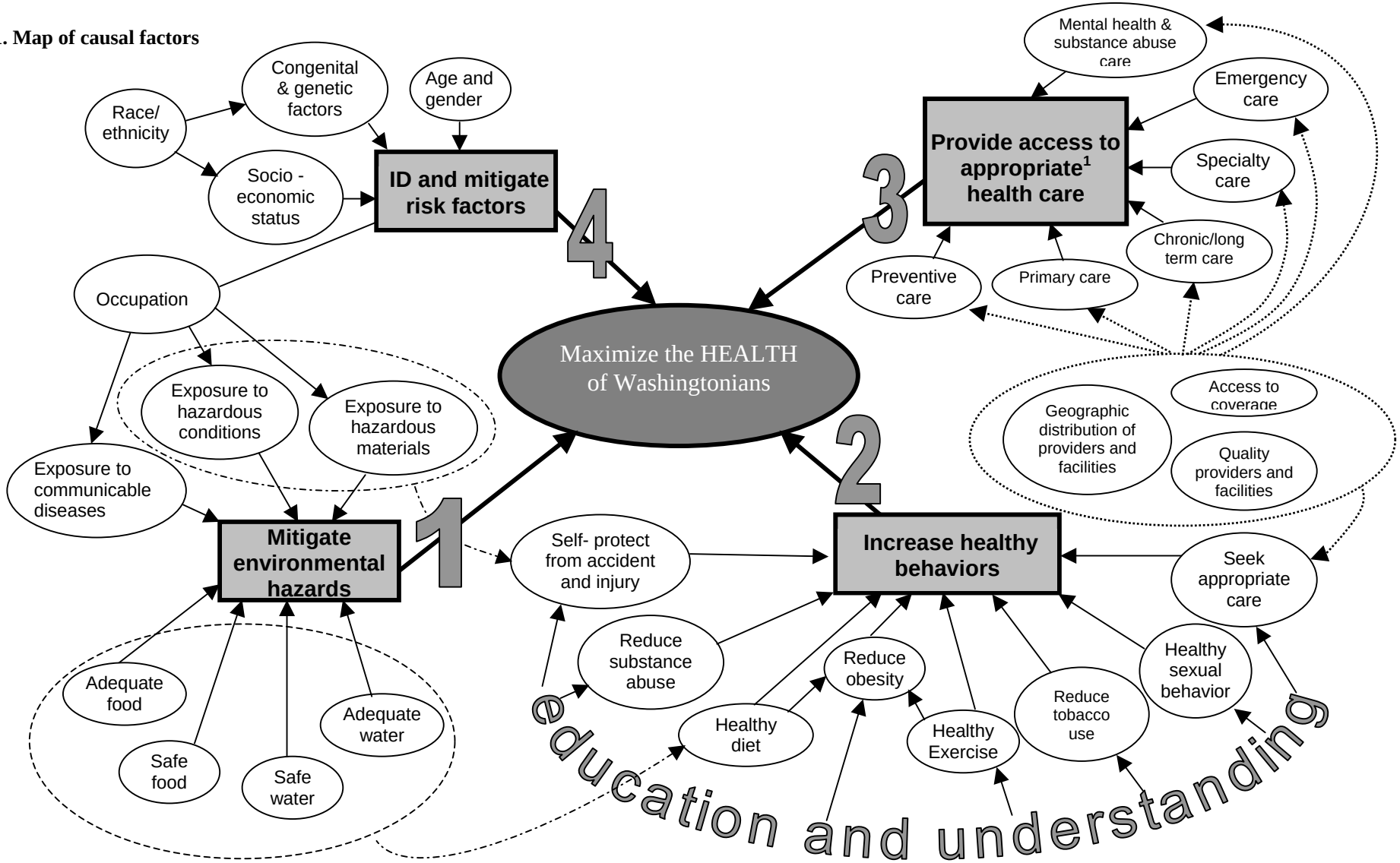
Improve the Health of Washington Citizens
Tollgate #2

1. Map of causal factors



[1] "Appropriate" means evidence-based, quality, and cost-beneficial care when applied to the design, treatment and delivery of health services

2. Assess the performance progress in this result area (Update - new information since Tollgate #1 only)

During the Tollgate #1 presentation, the Guidance Team asked for additional information about how the results of our tobacco prevention programs compare to other states. Specifically, the Guidance Team asked if there are data that measure the degree to which states' reductions in smoking rates can be attributed to prevention and control interventions rather than other factors such as increasing cigarette taxes.

Answer

There is a significant body of research literature on the effectiveness of tobacco prevention and control programs. The paper by Farrely, Pechacek and Chaloupka in the 2003 *Journal of Health Economics* is particularly well done but somewhat technical in nature. The authors conclude that funding such programs reduces tobacco use. They control for tax increases, taxes in neighboring states and the history of program expenditures. They conclude that if states had funded programs at the Center for Disease Control (CDC) recommended $6.00 per capita continuously since 1994, they would have doubled the rate of decline in sales.

In our state, the tobacco prevention and control program was initiated in 2001. There was a large (19.6 percent) reduction in taxed cigarette sales per capita between 2001 and 2002. The timing is generally consistent with an impact of the program, but it also coincides perfectly with the implementation of Initiative 773, which imposed a sixty-cents-per-pack tax on cigarettes. The magnitude of the change, however, is larger than predicted on the basis of price elasticity. The difference between the simple impact of an effective price change and the actual reduction has to be divided into two components. The first is the impact of the program. The second is the conversion of cigarette sales in the state of Washington into illegal, untaxed sources. The simple fact of the 19.6 percent reduction in sales is easily available, but could be attributed to either lower consumption or shifting sales. Therefore, the indicator selected by the Team comes from self-reported rates of tobacco use collected on the Behavioral Risk Factor Surveillance System (BRFSS) rather than from state rates of tobacco sales.

3. Propose high-level purchase strategies for this result area. What are the key areas where the state should take action, and how (if known at this point)?

The Health Team has reaffirmed its overall approach developed in POG I for improving the health of Washington residents. The team mapped the factors that affect health, looked at literature describing the degree to which certain factors affect health more than others, and agreed on overall tactics for improving health.

Our first priority for assuring that Washingtonians are healthy is to focus on providing population-based approaches and interventions to mitigate environmental hazards and increase healthy behaviors. We envision a health care system that provides population-based preventative care, assures that all Washingtonians will have access to emergency and trauma services and that low-income vulnerable populations will have access to evidence based health care.

The major strategies the Team identified that yield this result, in priority order, are:

1) Mitigate Environmental Hazards
   Examples of this strategy would be protecting the public from widespread sources of disease—including animal-borne diseases—in the environment through such activities as ensuring clean air and drinking water, inspecting restaurants' food handling practices, immunizing children and adults, and reducing exposure to communicable disease.

2) Increase Healthy Behaviors
   This strategy involves public outreach and education about individual behavior that contributes to good health. Preventable diseases are responsible for almost half the deaths in the United States. Smoking prevention programs or education about healthy sexual behavior would be examples.

3) Provide Access to Appropriate Health Care
   The state provides direct health care coverage or assistance with coverage to certain vulnerable groups such as children and low-income, elderly and disabled persons, and works to improve and monitor the quality and capacity of the health system (health facilities and health professions). When we buy direct coverage for residents, we should strive to purchase safe and effective care – that is, evidence-based, quality, and cost-beneficial.

4) Identify and Mitigate Risk Factors
   Examples of this strategy would be science-based activities to collect health information through a variety of systems, including mandatory disease reporting and vital records. This information would be analyzed to detect patterns, and results used to prevent further spread of disease or to target at-risk populations. An example would be the newborn screening program and follow-up for congenital diseases.

4. Provide guidance to agencies for budgets, analysis and legislation

A. Identify operational or legal barriers to the implementation of the high-level strategies.

Barrier: Categorical funding from federal government to state, and state to local government decreases the public health system's ability to adapt to changing or differential needs.
Strategy: Seek flexibility options with the federal government. Look for opportunities to redesign funding stream from state to locals to increase local flexibility while adding accountability and achieving core competencies. Look for opportunities for small packages of funding to be combined into larger, single packages (bundling).

Barrier: State funding for healthcare is characterized by a structural deficit. State revenue growth for the coming biennium is projected to be four to six percent per year whereas health costs continue to grow at double-digit rates.
Strategy: For the short-term, continue to pursue opportunities such as concentrating on interventions with the greatest return on investment (ROI) and that have the greatest promise for aligning with the strategy map. A long-term strategy is more complex and will include partners at many levels of the health care service system, the public, government, and private sector.

Barrier: While state government shoulders a heavy burden in paying for health care costs, state law sometimes prevents government from employing the most population-based interventions to prevent disease and injury as well as decrease health care costs. Examples might include issues surrounding the limitations of the state's clean indoor air act and the inconsistencies in water fluoridation throughout the state.
Strategy: Consider altering state law to allow for more population-based interventions, focusing specifically on those interventions that will decrease injury and disease and result in decreased health care costs. Successful examples of this approach include helmet and seatbelt laws.

Barrier: Federal law, rule, and associated court cases place restrictions on states' ability to administer their Medicaid program. States are limited as to whom they cover (categorical mandatory and optional groups), benefit coverage that can be offered, and the ability to use financial incentives (e.g., co-payments) where appropriate. States may be presented with so-called "block grant" options that provide more flexibility but shift risk from the federal government to states.
Strategy: Consideration should be given by the federal government to a more flexible program based on the so-called per-capita cap model that would retain entitlement to coverage.

Barrier: Better, more organized data are needed.
Strategy: A state warehouse of healthcare data or an integrated database could ensure we do not duplicate efforts across agencies and could leverage information-gathering opportunities across programs. We have key gaps in data that, if filled, would enhance our assessment and monitoring of the capacity and quality of our health systems. For example, outpatient hospital business represents 70 percent of hospital patient volumes yet our state does not include outpatient data (including emergency room activity or ambulatory services) in its required reporting from hospitals. Neither do we collect data from clinics, where an increasing amount of health care is delivered. Another possibility would be a full assessment of the pool of providers. We have anecdotal evidence that physicians are leaving the state but no data against which to check the extent to which this occurs.

B. Identify opportunities to reduce the price or improve the efficiency of current services.

In addition to specific suggestions provided below, the Health Team would request that a few more tools be added to those provided in the Team Process Guide for screening whether the right things are being done right. The health agencies should also ask themselves the following questions:

Are there options for earlier, preventative interventions?
Is it evidence-based?
Are we paying the right price?
Is it properly coordinated for maximum impact?
Are there measures of performance?
Are there opportunities for outcome-based contracts?

Specific suggestions to reduce the price or improve the efficiency of current services:

- Develop a state web site of evidence-based and uniform practices for wide, immediate dissemination of information. Building on—or actively using—existing web-based tools such as those developed by the Agency for Healthcare Research and Quality (AHRQ) could accomplish this. Another alternative would be collaborating with other entities such as the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), or the University of Washington.

  Best practices need to be defined, disseminated, and adopted. The state has opportunities to steer adoption of best practices through regulating and motivating providers and through its purchasing decisions. State health purchasers need to be accountable for performing many of these functions. One possibility for motivating providers to adopt best practices would be to collect data on provider performance, rate providers based on the degree of adherence to best practice standards, and post the ratings on the Internet.

- Explore opportunities to develop, coordinate and centralize health planning and information across state health activities to eliminate duplication of effort and leverage resources and information. One possibility would be an expanded coordination role for a sub cabinet-type entity, with dedicated professional staff resources.

- Health care facilities are currently inspected by numerous state agencies. Likewise health care professionals are sometimes regulated by multiple state agencies. Agencies should explore opportunities to further consolidate routine inspection/regulatory activities – building on the work of the Hospital Inspection Coordination group.

- Look across all agencies for operations and administrative policies that can be streamlined. An example of this approach is DSHS's "Enterprise Architecture" project. The department is using a variation of a method developed by IBM to improve computer systems, and is designed to analyze existing structure for the purpose of streamlining operations within an agency and—to the extent possible—establishing common definitions and procedures.

- Develop strategies across agencies to implement HB 1299, which directs agencies to develop and implement uniform policies that will ensure purchasing safe and effective health services, improve the quality of care provided across state health programs, and reduce administrative burdens on health care providers.

- Examine the role of government versus employers in providing health coverage.

C. Identify new initiatives and areas of budget focus that should be pursued based on Tollgate #1 and #2 analysis.

The Health Team has identified a number of areas with potential for advancing progress toward improving the health of Washington residents. These areas of potential intervention fall largely within one of the main strategies.

One area, however, spans across three of the four strategies (#1, #2, #4) and involves improving the capacity of the public health infrastructure to ensure that public health needs are met statewide. The public health infrastructure is the network of state and local health departments that provides public health protection throughout Washington state. Drinking water safety and restaurant inspections, tobacco use prevention, investigation of disease outbreaks, preparation for emergencies, disease prevention and control, immunization programs, and newborn screening are among essential services to protect the public's health.

Other new areas of initiative and the major strategies with which they are associated:

1) Mitigate Environmental Hazards
   a. Assure local public health districts' capacity to address environmental health issues
   b. Identify strategic options that could be applied to address emerging diseases, such as zoonotic (animal-borne) diseases.
   c. Coordinate with K-12 Team regarding their commitment to making children "school ready" by addressing prevention and keeping children healthy. Recommend the K-12 Team, in their efforts to create "learning ready schools," that schools be assessed relative to safe water, air, and noise levels in the physical facility environment.
   d. Examine health disparities[1] in the realm of environmental health.

2) Increase Healthy Behavior
   a. Provide options for evidence-based interventions to prevent high-risk behaviors such as alcohol/substance abuse.
   b. Find ways to leverage school districts' influence, growth management standards, capital facilities construction (showers, bike racks, walker-friendly stairs) to promote physical activity. This could include new investment or re-alignment of current investments.
   c. The three health agencies should look at development of a deep, comprehensive plan to address overweight/obesity. Include opportunities to target state-covered populations (state employees, Basic Health enrollees, Medicaid clients).
   d. State purchasing agencies should look at opportunities to tie financial strategies or contract requirements to improving healthy behaviors. Examples would be accountability to certain outcome measures, differential rates for smokers versus non-smokers, flu shot rates, or immunization rates. These incentive strategies should be investigated for our contractual partners (e.g. insurance carriers and hospitals) as well as individual consumers, and should include reward and recognition for "best practices."
   e. Examine the use of population-based, cost-effective injury prevention strategies. What would be the benefit/cost or a potential area of intervention to prevent injuries?
   f. Examine health disparities in the realm of healthy behaviors.

[1] Health disparities – differences in morbidity and mortality due to various causes experienced by specific sub populations.

3) Provide Access to Care
   a. Evaluate the current research relating to the preventive value of dental care. What are potential options, including benefit/cost analysis, for a consistent adult dental package for both Basic Health enrollees and Medicaid clients and what would it cost? What is the return on investment (ROI) over other acute care costs?
   b. Examine cost offset between alcohol/substance abuse treatment and ER use or other acute health care costs.
   c. Suggest opportunities to make evidence-based investments in prevention and treatment for mental health care.
   d. Prioritize evidence-based care (across the range of our health care purchases and across agencies). What strategies help us move toward the goal of evidence-based purchasing and what key priorities provide the next steps?
   e. The three primary health agencies should work together and with local communities to assess opportunities for fundamental health planning across the system and suggest the most effective approach for implementation.
   f. State agencies should develop and adopt financial incentives or contract requirements that foster healthy behaviors and implement preventive care strategies selected by the agencies to reduce the need for medical care (ties to 2d above).
   g. Examine the possibility of applying the Enterprise Architecture model to health purchasing across the agencies.
   h. Explore options for leveraging federal funding to pay for additional Basic Health slots, or other options that maintain our commitment to serving low-income adults.
   i. Examine Uniform Medical Plan and Medicaid fee-for-service reimbursement rates across provider specialties.
   j. Assess current numbers of providers, trends, and ratios of types of providers-to-residents. Propose standards for establishing ratios for various types of providers. What additional tools should we invest in to more accurately monitor the quality and capacity of our health system – and which tools provide the greatest ROI?
   k. Examine health disparities in the realm of access.

4) Identify and Mitigate Risk Factors
   a. Look for systematic steps that could be taken by the state to take into account health disparities with regard to race and ethnicity.
   b. Examine the state's role in genetic testing and markers.
   c. Assess whether there are new opportunities in newborn screening follow up.

D. Identify specific research projects and budget proposals that may aid the team's development of the detailed purchase plan in the fall.

Addressed in "C" above.